MAIL THIS APPLICATION TO:
Department of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

APPLICATION TO REOPEN CV CLAIM FOR AGGRAVATION OF CONDITION

Claim No.
Date closed
Date of birth
Date of injury

IMPORTANT: Do not use this form if present condition was caused by or aggravated by a new traumatic injury or event if less than 60 days has elapsed since closure. A letter will be sufficient to reopen.

VICTIM INFORMATION

Name of victim	Victim's Phone No. ( )	Soc. Sec. No.
Present home address	Mailing address, if different from home address:	
City State ZIP	City State ZIP	

If employed, employer at time of original injury: Address City State ZIP+4

Name of physician or counselor at time of closure:

Name part or parts of body injured:

Date condition became worse since closing of claim: / /	Did condition become worse due to another injury? Yes ☐ No ☐ If yes, explain:

Please describe symptoms:

Are you working? Yes ☐ No ☐	If not, give reason and last date worked: quit ☐ retired ☐ laid off ☐ unable to work ☐	Present or last employer
		Date / Claimant's or legal guardian's signature

INSURANCE

All insurance resources must be listed below (this includes welfare, health, auto, life, workers comp., etc.).

Check this box **ONLY** if you have no insurance ☐

	Insurance Company Name	Name of Policy Holder	Policy Number
Health	Effective date / /		
Public Assistance/Medicaid (case number)	Effective date / /		
Medicare claim number	Effective date / /		
Other: (name, type etc.)			
Is the victim a union member? ☐ Yes ☐ No		If yes, what union?	

Did or will the victim receive any time loss compensation while off work for this injury? ☐ Yes ☐ No ☐ Maybe

If yes, from which of the following sources: ☐ Disability insurance ☐ Unemployment compensation ☐ Workers compensation ☐ Other: _____ ☐ Sick leave ☐ Social Security

RESOURCES

What is/was the monthly income of the victims' household? (Check one)

- ☐ More than $000.00 but less than $486.00
- ☐ More than $486.00 but less than $592.00
- ☐ More than $592.00 but less than $667.00
- ☐ More than $667.00 but less than $742.00
- ☐ More than $742.00 but less than $858.00
- ☐ More than $858.00 but less than $975.00
- ☐ More than $975.00

How many people are in the victims' household? _____

How many people in the victims' household are/were financially dependent on the victim? _____

Continued on reverse

AUTHORIZATION & SIGNATURE

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I have applied for benefits under the Washington Crime Victims Compensation Act. It is my responsibility to furnish the Department of Labor and Industries all information necessary to the administration of my claim.

Accordingly, I authorize and request any person having such information, including all past law enforcement records concerning me, to release it to the Washington Department of Labor and Industries, Crime Victims Compensation Program. This release shall apply to all possessors of information which might be relevant to my claim, including, but not limited to, private and governmental physicians and hospitals; local and federal law enforcement and prosecutors offices; local and federal court personnel; and employer; and any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization.

A reproduction of this signed authorization shall be treated in the same fashion as the original.

Print name | Social Security Number (for ID only)

Date | Signature

PHYSICIAN/MENTAL HEALTH PROVIDER

AUTHORIZATION FOR RELEASE OF RECORDS, DOCTOR'S OR COUNSELOR'S REPORT

ATTENTION: Payments of treatment and time loss benefits are limited to 60 days prior to receipt of this form by the Department of Labor & Industries. Payment will be made to the doctor for the office call and diagnostic studies necessary to complete this form. All other payment will depend upon acceptance of the reopening request. This application should be mailed to the department on the same day the patient is seen by you.

Have you examined claimant since claim was closed?
Yes ☐ No ☐ When? / /
Present complaints:

Physical or psychological examination in detail, listing all objective findings referable to complaints and areas involved in claim. If evaluating a mental condition, please give relationship of all symptoms to the covered assault. Is there a preexisting psychological condition that will retard recovery?

Diagnosis: (use both standard description and ICDA code)

Acute ☐ Chronic ☐

Has there been additional trauma or injury involved?
Yes ☐ No ☐ If "Yes," explain:

Est duration of treatment:

What are specific recommendations for treatment?

Is present condition result of the natural progression of an unrelated condition or a preexisting condition? Yes ☐ No ☐ If "Yes," explain:

Is claimant working? Yes ☐ No ☐ If not, is it because of his/her injury only? Yes ☐ No ☐ If not, explain:

Providers must complete this section in full!

No medical or hospital bill will be paid on closed claims

Provider's name (type or print) | Fed. Tax ID.

Address

City | State | ZIP+4

Date | Provider's signature | Telephone

Were you treating the victim at time of closure? Yes ☐ No ☐

If yes, please answer # 1

1. Is condition due to injury worse since closure? Yes ☐ No ☐

If yes, answer 2, 3, 4, or 5.

2. Probably ☐
3. Possibly ☐
4. Subjectively ☐
5. Objectively ☐

Dept. use only